

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State/Territory: Florida

Requirements for Third Party Liability-
Payment for Claims

433.139(b)(3)
(ii)(C)
55 FR 1423

Recipient third party liability information is sent to the Medicaid agency by IV-A and IV-D district workers. As a result of the information obtained, a claims cost avoidance system as outlined in 42 CFR 433.139 is utilized to determine provider compliance with billing instructions. An insurance coverage specific matrix determines the claims various categories of service which are or might be covered by the available third party resource.

All claim types pass through the TPL cost avoidance subsystem. However, in the following circumstances, post payment recovery is instituted rather than cost avoidance:

- o Medical services provided for prenatal, labor and delivery, or post partum care, except for inpatient hospital claims;
- o Medical services provided for preventive pediatric care, including early and periodic screening, diagnosis and treatment (EPSDT) examinations;
- o Pharmacy services provided to recipients who are covered by any health insurance policy except a health maintenance organizations (HMO) coverage or a separate pharmacy card. Pharmacy services provided to these recipients are cost avoided.

Providers are instructed to bill third parties for medical services rendered to Medicaid recipients with coverage maintained by an absent parent whose obligation to pay support is being enforced by the state title IV-D agency. If the insurance carrier denies the claim, the provider must attach the denial to the claim before submitting to medicaid. If the insurer refuses or fails to respond to the claim within 30 days of the date of service, providers may submit bills to Medicaid provided the claim includes a certification statement from the provider that the provider waited 30 days and no response was received from the third party. The TPL office then pays the provider and chases the claim.

TN No. 93-46
Supersedes
TN No. 92-19

Approval 5-12-94

Effective 7/1/93
Revised Submission 4/1/94

If a provider claim is received by the system without this documentation, the system rejects the claim, returns it to the provider and instructs the provider to bill the third party. Claims received which have an insurance carrier attachment, or the provider's certification that he has billed the third party, waited thirty days from the date of service and has not received a response from the insurance carrier, are reviewed by the Insurance Resource Section staff. That staff reviews the claim and attached provider certification or carrier Explanation of Benefits (EOB). Claims with carrier denials are processed and the provider's claim is paid. Claims with certification letters are "paid and chased" by the Insurance Resource Section staff.

433.139(f)(2)
50 FR 46652

The agency bills on a monthly basis all claims to insurance carriers regardless of the amount of the claim payment. No threshold amount or other guidelines are used in determining whether to seek reimbursement from a liable third party.

433.139(f)(3)
50 FR 46652

The agency does not accumulate billings with respect to a particular liable third party prior to billing. All bills, regardless of the amount of the claim are billed each month.

42 CFR 447.20
55 FR 1423

In the case of an individual who is eligible for medical assistance under the plan for services for which a third party is liable for payment, if the total amount of the established liability of the third party for the service is:

(a) equal to or greater than the amount payable under the state plan, the provider furnishing the service to the individual may not collect from the individual or any financially responsible relative or representative of that individual the payment amount for that service; or

TN No. 93-46
Supersedes
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(b) less than the amount payable under the state plan, including share of payments, the provider furnishing the service to the individual may collect from the individual or any financially responsible relative or representative of the individual an amount which is the lesser of:

- (i) any cost sharing payment amount imposed upon the individual by the Medicaid agency; or
- (ii) an amount which represents the difference between the amount payable under the state plan and the total of the established third party liability for the service.

Providers may not refuse to furnish services covered under the plan to an individual who is eligible to medical assistance under the plan on account of a third party's potential liability for the service.

433.145-.148

The requirements for assignment of rights and cooperation in establishing paternity and obtaining support under 433.146 through 433.148 are met.

As a condition of eligibility, each legally able applicant and recipient must assign their rights to medical support or other third party payments to the Medicaid agency and cooperate with the agency in obtaining medical support or payments.

In addition, Florida law provides that the recipient is deemed to have assigned their rights to third party payments to the Medicaid agency.

433.151-.154

Pursuant to Medicaid Program Issuance Transmittal Notice MCD-67-92, July 8, 1992, the Medicaid agency has chosen the option to terminate the cooperative agreement with the IV-D agency.

TN No. 93-46
Supersedes
TN No. NEW

Approval 5-12-94

Effective 7/1/93

Revised Submission 4/1/94